PRINTED: 02/25/2021 FORM APPROVED OMB NO. 0938-0391

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G  | (X3) DATE SURVEY COMPLETED C |
|--------------------------|--|--|--------------------------|--|------------------------------|
|                          |  | 495227   | B. WING _                |  | 01/21/2021                   |
|                          | PROVIDER OR SUPPLIER   | N AND NURSING CENTER   |                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br>7300 FOREST AVE<br>RICHMOND, VA 23226                             |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETION             |
| E 000                    | Initial Comments   |  | E 00                     | 0  |                              |
| F 000                    | Preparedness CO conducted onsite a 1/21/21. The facilit compliance with 4: Requirement for L INITIAL COMMEN  An unannounced Focused Survey wremotely 1/19/21 twere investigated VA00050433, VA0 substantiated with VA00050458, and unsubstantiated. compliance with F  | abbreviated COVID-19<br>vas conducted onsite and<br>hrough 1/21/21. Complaints   | F 00                     | 0  |                              |
| F 883<br>SS=E            | 199. Of the 199 cu<br>were positive for the<br>sample consisted<br>(Residents #3, #4,<br>and #14 through #<br>reviews (Residents<br>Influenza and Pne<br>CFR(s): 483.80(d)<br>§483.80(d) Influent<br>immunizations<br>§483.80(d)(1) Influent<br>policies and proce<br>(i) Before offering<br>each resident or the<br>receives educations | 225 certified bed facility was arrent residents, 34 residents ne COVID-19 virus. The survey of 23 current residents #5, #6, #7, #9, #10, #11, #12, 27) and 4 closed record s #1, #2, #8 and #13). umococcal Immunizations (1)(2) and pneumococcal renza. The facility must develop dures to ensure that the influenza immunization, he resident's representative a regarding the benefits and cts of the immunization; | F 88                     | 3  | 2/8/21                       |
| ABORATOR                 | Y DIRECTOR'S OR PROV   | IDER/SUPPLIER REPRESENTATIVE'S SIGN  | VATURE                   | TITLE  | (X6) DATE                    |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

02/04/2021

|                          | OF CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDII          | NG  |           | TE SURVEY<br>MPLETED       |
|--------------------------|---|---|---------------------|---|-----------|----------------------------|
|                          |   | 495227  | B. WING _           |   | 01        | C<br>/21/2021              |
|                          | PROVIDER OR SUPPLIER  DRT REHABILITATION  | N AND NURSING CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>7300 FOREST AVE<br>RICHMOND, VA 23226                  |           | 72172021                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 883                    | (ii) Each resident is immunization Octo annually, unless the contraindicated or immunized during the (iii) The resident or has the opportunity (iv) The resident's indocumentation that following:  (A) That the reside was provided educe and potential side to immunization; and (B) That the reside immunization or distinguished immunization due to refusal.  §483.80(d)(2) Pneumust develop policitation; (ii) Before offering to immunization, each representative receivenefits and potentimmunization; (iii) Each resident is immunization; (iii) Each resident is immunization unle medically contrained already been immunication; (iv) The resident or has the opportunity (iv) The resident's indocumentation that following:  (A) That the reside | de offered an influenza ober 1 through March 31 or immunization is medically the resident has already been this time period; the resident's representative to refuse immunization; and nedical record includes indicates, at a minimum, the ent or resident's representative ation regarding the benefits effects of influenza of the influenza of medical contraindications or almococcal disease. The facility is and procedures to ensure the pneumococcal in resident or the resident's elives education regarding the inal side effects of the | F 88                | 33  |           |                            |

| A. BUILDING  A. BUILDING  A. BUILDING  COMPLETED  NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER   STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 883  Continued From page 2  F 883  | .ETED                      |
|--|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  7300 FOREST AVE RICHMOND, VA 23226  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | /2021                      |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | /2021                      |
| F 883 Continued From page 2 F 883  | (X5)<br>COMPLETION<br>DATE |
| and potential side effects of pneumococcal immunization; and  (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.  This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain and implement an immunization program for the influenza and pneumococcal vaccines for five of 27 residents in the survey sample, (Resident's #3, #4, #5, #6, and #7).  The facility staff failed to ensure the immunization status was assessed, documented in the clinical record and vaccinations were offered to Resident #3, #4, #6 and #7 and failed to provide education to the resident and/or responsible party before administering a vaccination to Resident #5 and #7.  The finding include:  1. The facility staff failed to evidence documentation in the clinical record that Resident #3 sand pneumococcal immunization records validated, updated and documented.  1. The facility staff failed to evidence documentation in the clinical record that Resident #3 shad already been immunized or that the immunizations were medically contraindicated.  Resident #3 was admitted to the facility on 12/17/2020 with diagnoses that included but were not limited to pneumonia (An infection in one or 12/17/2020 with diagnoses that included but were not limited to pneumonia (An infection in one or 12/17/2020 with diagnoses that included but were not limited to pneumonia (An infection in one or 12/17/2020 with diagnoses that included but were not limited to pneumonia (An infection in one or 12/17/2020 with diagnoses that included but were not limited to pneumonia (An infection in one or 12/17/2020 with diagnoses that included but were not limited to pneumonia (An infection in one or 12/17/2020 with diagnoses that included but were not limited to pneumonia (An infection in one or 12/17/2020 with diagnoses that included but were not limited to pneumo |                            |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD | TIPLE CONSTRUCTION  |  | ) DATE SURVEY<br>COMPLETED   |
|--------------------------|---|--|----------------------|---|--|------------------------------|
|                          |   | 495227   | B. WING              |   |  | C<br><b>01/21/2021</b>       |
|                          | PROVIDER OR SUPPLIER  DRT REHABILITATION  | N AND NURSING CENTER   |                      | STREET ADDRESS, CITY, STATE, ZIP C<br>7300 FOREST AVE<br>RICHMOND, VA 23226   |  | 01/21/2021                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  |   | N SHOULD BE  | (X5)<br>COMPLETION<br>E DATE |
| F 883                    | both of the lungs. No viruses, and fungi, congestive heart fat characterized by cirretention of salt and anemia (condition is content of the blood and gastroesophage the contents of the usually caused by muscle between the usually caused on the BIMS (brief is score, indicating the impaired to make discort, indicating | Many germs, such as bacteria, can cause pneumonia) (1), can cause pneumonia) (1), can cause pneumonia) (1), can cause pneumonia) (1), can cause pneumonia) (2), can cause by the kidneys) (2), can which the hemoglobin do is below normal limits) (3), cal reflux disease (backflow of stomach into the esophagus, malfunction of the sphincter e two organs) (4).  DS (minimum data set) dicare five day assessment, assment reference date) of the resident as scoring a "9" interview for mental status) e resident was moderately laily cognitive decisions.  I Treatments, Procedures and ented in part; "Did the resident as vaccine in this facility for this coination season?" A "No" was a vaccine not received, state ving was coded "Resident not tion 0300 documented, "is the coccal vaccination up to date?" | F8                   | affected by the same deficies residents have the potential affected. Influenza and Pne Immunization audit of all rescompleted on 2/3/2021.  3. Address what measures into place or systemic changensure that the deficient prarecur: Education was provious staff on immunization policies procedures by Director of Non 2/4/2021.  4. Indicate how the facility promonitor its performance to resolutions are sustained: D.C. complete weekly audits of neadmissions verifying that Resolfered influenza and pneum immunization, education contadministered if accepted and documented. Audits will be sweeks and monthly for 2 modeficits occur they will be for QAPI Monthly.  5. Include dates when the action will be completed: Data compliance 2/8/2021. | I to be sumococcal sidents was swill be put ges made to actice will no ded to nursi es and lurse initiate plans to make sure to D.N. will new esident are mococcal mpleted and weekly for 4 porths. Should rwarded to corrective | t o o oot ing ed that        |

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(X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIF<br>A. BUILDING   |                     | (X3) DATE SURVEY COMPLETED C                    |           |                            |
|--|--|--|---------------------|---|-----------|----------------------------|
|  |  | 495227   | B. WING             |   | 01        | /21/2021                   |
|  | PROVIDER OR SUPPLIE  | ON AND NURSING CENTER  |                     | G COMPLICE C C C C C                            |           |                            |
| (X4) ID<br>PREFIX<br>TAG   | (FACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 883  | the resident rece facility for this ye season?" It was influenza vaccine Resident not in t was blank. "2 Is vaccination up to 2a. If pneumoco state reason, "No On 1/19/2021 at was made to the documentation r immunization sta pneumococcal v received.  On 1/21/2021 at conducted with A member) #2, the stated there was resident's influer status in the clin When asked wh vaccination status stated the infect asked about the assessing and a #2 stated on ad assessment has status. It should infection preven immunizations in preventionist wa  The facility polic documented in p pneumococcal v | page 4 sive the influenza vaccine in this ar's influenza vaccination documented as "No." "1a. If e not received, state reason: his facility." 1b. Influenza date the resident's Pneumococcal odate?" A "No" was documented. ocal vaccination not received, ot assessed" was documented.  12:47 p.m., an email request administrator for the elated to Resident #3's atus for the influenza and faccinations. No documents were as ASM (administrative staff of the income accination related to the first or pneumococcal vaccination ical record that she could find. The income accination is responsible for keeping the first of each resident, ASM #2 was process staff follows for administering vaccinations. ASM mission the admission a place for the immunization then be followed up on by the tionist who tracks the first of the facility. The infection is not available for interview.  12:09 p.m. an interview was as a process staff follows for the immunization in the facility. The infection is a place for the immunization of the facility. The infection is not available for interview.  13:47 p.m., an email request additional requestions was a process was a first or the infection in the facility. The infection is not available for interview.  14:47 p.m., an email request attention in the facility. The infection is not available for interview.  15:47 p.m., an email request attention in the facility. The infection in the facility. The infection is not available for interview. | F 883               | 3   |           |                            |

(X2) MULTIPLE CONSTRUCTION

| AND PLAN OF CO  | EFICIENCIES<br>RRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |        | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|--|---|--------|-------------------------------|----------------------------|
|   |  | 495227   | B. WING                                |   |        |                               | С                          |
| NAME OF PROV  | DER OR SUPPLIER  | 433227   | B. WING                                | CTREET ADDRESS SITU STATE TO  |        | 01/                           | /21/2021                   |
|   | REHABILITATION   | N AND NURSING CENTER   |  | STREET ADDRESS, CITY, STATE, ZIP CO<br>7300 FOREST AVE<br>RICHMOND, VA 23226                  | ODE    |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD | BE                            | (X5)<br>COMPLETION<br>DATE |
| Inte upo eligi seri vacci to the Assistate days prio The doce who vacci annotate the vacci influ Imple Mark be of the vacci imm admissible of | n admission, re ibility to receive es, and when in cine series withing facility unless resident has alressments of property of the resident of the mally to encourable was also and the series of the employed and the series of the series of the employed and the series of the | implementation: 1. Prior to or sidents will be assessed for the pneumococcal vaccine dicated, will be offered the in thirty (30) days of admission amedically contraindicated or eady been vaccinated. 2. eumococcal vaccination acted with in five (5) working its admission if not conducted with in five (5) working its admission if not conducted and residents and employees all contraindications to the red the influenza vaccine ge and promote the benefits cinations against terpretation and Between October 1st and ar, the influenza vaccine shall into and employees, unless cally contraindicated or the re has already been ployees hired or residents october 1st and March 31st vaccine within five (5) working res job assignment or the | F8                                     | 83  |        |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDE IVOCITY (X2) MOZIM 22 OCTOBER 200 |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 03 89              |                                       |           | DATE SURVEY<br>COMPLETED   |  |
|--|---|--|--------------------|---------------------------------------|-----------|----------------------------|--|
| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,                                  |   |  |                    |                                       |           | С                          |  |
|  |   | 495227   | B. WING            | STREET ADDRESS, CITY, STATE, ZIP C    |           | /21/2021                   |  |
|  | PROVIDER OR SUPPLIER  ORT REHABILITATION  | N AND NURSING CENTER   |                    | 7300 FOREST AVE<br>RICHMOND, VA 23226 | JODE      |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |                                       | SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 883  | (2) Barron's Diction Non-Medical Read Chapman, page 13 (3) Barron's Diction Non-Medical Read Chapman, page 33 (4) Barron's Diction Non-Medical Read Chapman, page 24 2. The facility staff documentation in the 4's immunization vaccine was assest declined or that Resident and were not limited to of mental disorder distortions of reality language, perception (1), osteomyelitis (marrow usually caperipheral vascula condition, including blood vessels outs). The most recent Massessment, with a the resident as soot the south of | failed to evidence he clinical record that Resident status for the pneumococcal sed, the vaccine was offered, esident #4, had already been the immunization Rothenberg the end was sed, the vaccine was offered, esident #4, had already been the immunization was | F                  | 383                                   |           |                            |  |

| STATEMENT<br>AND PLAN (  | FOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD | TIPLE CONSTRUCTION   |             | TE SURVEY                  |
|--------------------------|--|--|----------------------|--|-------------|----------------------------|
|                          |  | 495227   | B. WING              |  | 01          | C<br>1 <b>/21/2021</b>     |
|                          | PROVIDER OR SUPPLIER  DRT REHABILITATION   | N AND NURSING CENTER   |                      | STREET ADDRESS, CITY, STATE, ZIP<br>7300 FOREST AVE<br>RICHMOND, VA 23226                    |             | 1/2021                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG   | PROVIDER'S PLAN OF CO<br>X (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 883                    | In Section O - Spea and Programs, it w Pneumococcal vac was documented. note received, stated declined" was documented declined was documented to evic pneumococcal vac clinical record documentation (admiss 10/30/2020. The following the foll | cial Treatments, Procedures as coded, "2 Is the resident's cination up to date?" A "No" B. If Pneumococcal vaccine e reason: Offered and amented.  nunization Tab" in the clinical dence documentation of the cination. Further review of the amented in part, "Resident ion assessment)" dated orm in Section B1 - cumented, "Is the resident's cination up to date?" "Not nation" was coded. There was evidencing the vaccine had eclined.  147 p.m., an email request dministrator for the ted to the Resident #4's a for pneumococcal cuments were received.  15 onducted on 1/21/2021 at M #2, the director of nursing. Here is no documentation in the ed to his (Resident #4's) | F8                   | 883  |             |                            |

| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | S. Commonweal     |       | CONSTRUCTION  |           | TE SURVEY<br>MPLETED       |
|--------------------------|--|---|-------------------|-------|---|-----------|----------------------------|
| AND PLAN O               | F CORRECTION   | IDENTIFICATION NOMBER.  | A. BUILE          | ING   |   |           | С                          |
|                          |  | 495227  | B. WING           |       |   |           | /21/2021                   |
|                          | PROVIDER OR SUPPLIER  ORT REHABILITATION   | N AND NURSING CENTER  |                   | 7300  | EET ADDRESS, CITY, STATE, ZIP CO<br>D FOREST AVE<br>HMOND, VA 23226                           | DDE       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>I LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | 10000 | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 883                    | Chapman, page 5 (2) Barron's Diction Non-Medical Real Chapman, page 4 (3) Barron's Diction Non-Medical Real Chapman, page 4 3. The facility fails education was propried to administe Resident #5 on 1  Resident #5 was 11/1/2014, with donot limited to: demental decline, equivalently and ability disturbance) (2), reflux disease (bottomach into the malfunction of the two organs) (3).  The most recent assessment, with the resident as sindicating the re | onary of Medical Terms for the der, 5th edition, Rothenberg and 423. In the derest of Medical Terms for the der, 5th edition, Rothenberg and 447.  The description of Medical Terms for the der, 5th edition, Rothenberg and 447.  The description of Medical Terms for the derest of the | F                 | 883   |   |           |                            |

| AND PLAN                 | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION<br>G   |          | ATE SURVEY                 |
|--------------------------|--|--|--------------------------|---|----------|----------------------------|
|                          |  | 405007   |                          |   |          | С                          |
| NAMEOF                   |  | 495227   | B. WING _                |   | 01       | 1/21/2021                  |
| WESTPO                   |  | I AND NURSING CENTER   |                          | STREET ADDRESS, CITY, STATE, ZIP CO<br>7300 FOREST AVE<br>RICHMOND, VA 23226                      | DE       | -                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
|                          | vaccination on 10/3 Review of the "Imm record, documented influenza vaccination review of the clinical documentation of the for the influenza vaccination review of the clinical documentation of the for the influenza vaccination related and consent for the 10/30/2020. No do to completion of the An interview was confirector of nursing, of When asked about the education provided administration of the Resident #5 on 10/3 was no documentation the education and convaccine.  ASM # 1, the administration of the above concern of No further information in the Analysis of the Asmall Resident R | unization Tab" in the clinical of the resident received her non 10/30/2020. Further I record failed to evidence the electron education and the consent eximation.  47 p.m., an email request ministrator for the ed to Resident #5's education influenza vaccine received on cuments were received prior survey.  Inducted with ASM #2, the en 1/21/2021 at 12:09 p.m. documentation of the end the consent for the end the consent for the enfluenza vaccine to 0/2020, ASM #2 stated, there on in the clinical record for ensent for the influenza exaction in the clinical record for ensent for the influenza for the influenza was provided prior to exit.  Early of Medical Terms for the record of Medical Terms for th | F 88                     | 3   |          |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION  | (X3) DA | TE SURVEY<br>MPLETED       |
|---|--|--|-----------------------------|---|---------|----------------------------|
|   |  | 495227   | B. WING                     |   | 01      | C<br><b>/21/2021</b>       |
|   | PROVIDER OR SUPPLIER<br>DRT REHABILITATIO  | N AND NURSING CENTER   | 7:                          | TREET ADDRESS, CITY, STATE, ZIP CODE<br>800 FOREST AVE<br>ICHMOND, VA 23226                             |         | 72172021                   |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | ULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 883   | Non-Medical Read Chapman, page 24  4. The facility staff documentation in the Resident #6's imminfluenza and pneuronassessed, offered, had already been in immunizations were resident #6 was a 12/24/2020 with dinot limited to: diable encephalopathy (a (1))  The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment, with a second page 24  1. The most recent Massessment page 24  1. The most recent page 24  1. The most  | er, 5th edition, Rothenberg and 43.  | F 883                       | DETICIENCY)   |         |                            |
|   | indicating she was cognitive decisions requiring extensive staff members for living. In Section C Procedures and Procedures and Procedures and receivable in the facility was documented a during this year's in For the pneumocodashes documents completed.  Review of the "Imprecord only documents of the COVID vaccinations and the complete coverage of the coverage of t | capable of making daily s. The resident was coded as assistance of one or more most of her activities of daily - Special Treatments, rograms, the resident was ving the influenza vaccine The reason for not having it as, "Resident not in this facility influenza vaccination season." ccal vaccination, there were ad indicating it was not  nunization Tab" in the clinical ented the resident received a n on 1/20/2021. There was no on regarding immunizations in |                             |   |         |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD | TIPLE CONSTRUCTION ING   |        | E SURVEY<br>MPLETED        |
|--------------------------|--|--|----------------------|--|--------|----------------------------|
|                          |  | 495227   | B. WING              |  |        | C<br><b>/21/2021</b>       |
|                          | PROVIDER OR SUPPLIER  PRT REHABILITATION   | I AND NURSING CENTER   |                      | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226 |        | 21/2021                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  |  | JLD BE | (X5)<br>COMPLETION<br>DATE |
| F 883                    | the clinical record.  Further review of the in part, "Resident Eleassessment)" dated Section B1 - Immure the resident receive facility for this year's season?" It was do assessed/no informed Pneumococcal vaccoded as, "Not assessed/no informed Pneumococcal vaccoded as, "Not assessed/no informed Pneumococcal vaccoded as, "Not assessed/no informed Pneumococcal vacciones, and interview was confluentation of the An interview was confluentation of the Pneumococcal vacciones, by completion of the Pneumococcal vacciones, and the above concerning the above concerning the above concerning the Analysis of the Pneumococcal vacciones, and the above concerning the above concerning the Analysis of the Analys | de clinical record documented evaluation (Admission d 12/24/2020. The form in nizations, documented, "1. Did the influenza vaccine in this influenza vaccination ocumented as, "Not nation. 2 Is the resident's cination up to date?" It was essed/no information."  1:47 p.m. A request was made to via email for the ted to the resident's for the pneumococcal and No documents were received e survey.  Inducted with ASM #2 on p.m. When asked about the resident's influenza and cine status, ASM #2 stated e any information in the clinical inistrator, was made aware of the initial and the initial and the initial are provided prior to exit.  In ary of Medical Terms for the er, 5th edition, Rothenberg and | F 8                  | 83   |        |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION  NG   | COMPLETED       |                            |  |
|--|--|---|---------------------|---|-----------------|----------------------------|--|
|  |  | 495227  | B. WING _           |   | 01              | /21/2021                   |  |
| NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER |  |   |                     | 7300 FOREST AVE RICHMOND, VA 23226  | of september 11 |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE         | (X5)<br>COMPLETION<br>DATE |  |
| F 883  | was provided pricinfluenza vaccine and failed to evid immunization starvaccination was a offered/declined, been immunized medically contrain Resident #7 was 9/25/2020 with dinot limited to: deringh blood pressort The most recent assessment, with resident as scorin indicating the resmake daily cognicoded as requiring assistance of one activities of daily Treatments, Proceeding to date. In Section 10/22 resident as having up to date. In Section 10/22 resident as having it "Offered Review of the "In record document influenza vaccine influenza vaccine and failed price influenza vaccine influenza vac | Continued From page 12 was provided prior to the administration of the influenza vaccine to Resident #7 on 12/22/2020, and failed to evidence that the residents immunization status for the pneumococcal vaccination was assessed, the vaccine was offered/declined, or that the resident had already been immunized or that the immunization was medically contraindicated.  Resident #7 was admitted to the facility on 9/25/2020 with diagnoses that included but were not limited to: dementia, depression, anemia, and high blood pressure.  The most recent MDS assessment, a quarterly assessment, with an ARD of 1/2/2021, coded the resident as scoring a "4" on the BIMS score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring supervision to limited assistance of one staff member for most of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, coded the resident as having received the influenza vaccine on 10/22/2020. In O0300, it coded the resident as having her pneumococcal vaccination up to date. In Section B, it coded the resident as having it "Offered and declined."  Review of the "Immunization Tab" in the clinical record documented the resident received her influenza vaccination on 12/22/2020. There was no documentation of the resident's pneumococcal |                     | 33  |                 |                            |  |
|  | in part, "Resident<br>The form in Sect   | the clinical record documented<br>t Evaluation" dated 9/25/2020.<br>ion B1 - 1. Did the resident<br>enza vaccine in this facility for this  |                     |   |                 |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |  |  |  |
|--|--|--|--|--|---|-------------------------------|--|--|--|
|  |  | 495227   | B. WING                                |  | C 01/21   |                               |  |  |  |
| NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226 |   |                               |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T                             | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                               |  |  |  |
| F 883  | year's influenza sea assessed/no inform Pneumococcal vaccoded as "Not asse A nurse's note dated documented, "Verba (name of daughter) vaccine when availated A request for the doresident's immunizated vaccination and the vaccination was manadministrator on 1/1 documents were resurvey.  An interview was considered by p.m. with ASM documentation of the administration of the process of the companion of the companion of the vaccination status, A documentation in the ASM # 1, the administration in the above concern of the status of the process of the concern of the process of the concern of the process of | ason?" It was coded as "not nation. 2. Is the resident's cination up to date?" It was essed/no information."  ad, 10/15/2020 at 2:02 p.m. al consent obtained from to receive the Influenza able."  becamentation related to the ation status for pneumococcal education for the influenza ade by email to the 19/2021 at 12:47 p.m. No ceived by completion of the conducted on 1/21/2021 at M #2. When asked about the education provided prior to of the influenza vaccine to #2 stated she could not find it d. When asked about the ne resident's pneumococcal ASM #2 stated there was no | F8                                     | 83   |   |                               |  |  |  |